

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any, is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9654

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 10, 11, 12, & 14 Film G293 9/5/61 iwl

09647

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>3 V01-4</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural) Salisbury Md.</b>		c. LENGTH OF STAY IN 1b <b>One Day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greenway Motel Route #13</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore I5</b>	
f. STREET ADDRESS <b>4214 Hayward Ave.</b>		g. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Leonard Engle Ambrose</b>		4. DATE OF DEATH <b>8-21 19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-7-14</b>	
9. AGE (In years last birthday) <b>46 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rep. for Intn'l. Cir. Distribution</b>		14. BIRTHPLACE (State or foreign country) <b>West, Va. Harpers Ferry</b>	
15. FATHER'S NAME <b>Charles Clegg Ambrose</b>		16. MOTHER'S MAIDEN NAME <b>Rebecca Engle</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		18. SOCIAL SECURITY NO. <b>Beulah Ambrose 4214 Hayward Ave</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <b>416X RHEUMATIC HEART DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		20. INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
28. ACTUAL SIGNATURE <b>Earl R. Royer</b>		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
30. EXAMINER'S NAME (Type) <b>Dr. Earl R. Royer</b>		31. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
32. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		33. DATE SIGNED <b>8-24-61</b>	
34. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		35. DATE THEREOF <b>Aug 26/1961</b>	
36. NAME OF CEMETERY OR CREMATORY <b>Hoodlawn</b>		37. LOCATION (City, town, or country) (State) <b>Hoodlawn Md</b>	
38. FUNERAL DIRECTOR <b>Harry H. Amos</b>		39. ADDRESS <b>4204 Ridgewood Ave</b>	
40. REC'D BY REGISTRAR <b>AUG 28 '61</b>		41. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

\$651

Items 2, 7, 11 & 12 Film G293 8/24/61 mh

Items 8 & 9 Film G297 10/9/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 09642

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>23X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>BARNES</u> Last <u>BARNES</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1913</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u>47</u> Days <u>14</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS. Months <u>47</u> Days <u>14</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE ENCEPHALOPATHY</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO <u>8YR</u> (c) <u>8YR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS &amp; GANGRENE RT. LEG</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-9</u> , 19 <u>61</u> , to <u>8-14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8-14</u> , 19 <u>61</u> , and that death occurred at <u>8:25</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. J. Todd, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>PENINSULA GENERAL HOSP 8-15</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>NEVINS W. J. TODD, JR.</u>		SALISBURY, MARYLAND	
22a. BURIAL (CREMATION) REMOVAL (Specify) <u>8-16-61</u>		22b. DATE THEREOF <u>8-16-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>W. J. Todd, Jr. Med School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Braden West</u> ADDRESS <u>Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 21 '61</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

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9652

## CERTIFICATE OF DEATH

Reg. Dist. No. 09643

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirdditue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>W.</u> Last <u>BARNES</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 17-1873</u> AGE (In years last birthday) <u>78 4/1</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Shirdditue, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Watson</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>8-17</u> , 19 <u>61</u> , to <u>8-18</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8-18</u> , 19 <u>61</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>Aug. 18, 1961</u>			
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 20 1961</u>		<u>Snow Hill Cemetery</u>		<u>Shirdditue, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Way E. Pinnis</u> ADDRESS <u>Snow Hill, MD</u>				24. REC'D BY REGISTRAR DATE <u>AUG 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*John*

*April 17-1922*

*John*

*John*

*John*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9653											
09644											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springhill Sanitarium</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Maurice</b> Middle <b>Schoolfield</b> Last <b>Barnes</b>						4. DATE OF DEATH Month <b>August</b> Day <b>14</b> , Year <b>19 61.</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-17-1881</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Clarence F. Barnes</b>						14. MOTHER'S MAIDEN NAME <b>Ethlyn Lankford</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>--</b>					
17. INFORMANT <b>Mrs Ethlyn Barnes Rankin, Maryland</b>						Address <b>Pocomoke City,</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>4200</b> DUE TO <b>Coronary Thrombosis</b> <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/14/61</b> , 19 <b>61</b> , to <b>8/15/61</b> , 19 <b>61</b> ; that (I) (we) last saw the deceased alive on <b>8/14/61</b> , 19 <b>61</b> , and that death occurred at <b>3:30 P.M.</b> from <b>the</b> causes and on the date stated above.											
22a. SIGNATURE <b>Dr. Andrew C. Mitchell</b>						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>						22d. ADDRESS <b>211 Maryland Ave., Salisbury, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-17-61</b>		23c. NAME OF CEMETERY <del>XXXXXX</del> <b>Salem Methodist</b>				23d. LOCATION (City, town or county) (State) <b>Pocomoke City, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>						ADDRESS <b>Pocomoke City, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 18 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
Item 2 Film 8292 8/11/61 iwk  
09645

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN TB <u>9 Days</u>		d. STREET ADDRESS <u>S. Division St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>M.</u> Last <u>Beasley</u>		4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/3/1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>61</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>---</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>---</u>		14. MOTHER'S MAIDEN NAME <u>---</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital Records -- Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>491X</u> (c), stating the underlying cause last, DUE TO (c) <u>Arteriosclerosis, General --- Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/27/61</u> , 19 <u>61</u> , to <u>8/5/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/5/61</u> , 19 <u>61</u> , and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. Maldve</u>		22b. DATE SIGNED <u>8/5/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Maldve, M.D.</u>		22d. ADDRESS <u>Deer's Head Hospital, Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/7/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SALEM METH. CEMET.</u>		23d. LOCATION OF CEMETERY OR CREMATORY <u>SALISBURY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HILL &amp; JOHNSON Co.</u>		25a. REC'D BY REGISTRAR <u>George C. Hill</u>	
ADDRESS <u>SALISBURY, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>AUG 8 '61</u>			

(M)

(1)

6555

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6555

None

10

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9655

## CERTIFICATE OF DEATH

Reg. Dist. No.

09646

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne R.F.D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TENINUSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>19X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Rebecca</u> Last <u>Bloodsworth</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1900</u>
9. AGE (In years lost birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Atlanta, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas P. Watts</u>		14. MOTHER'S MAIDEN NAME <u>Julia O'Shields</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
INFORMANT Address <u>Lester I. Bloodsworth Pr. Anne, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>465X Pulmonary Embolism</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis, chronic</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>8/19</u> , 19 <u>61</u> to <u>8-26</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8-26</u> , 19 <u>61</u> , and that death occurred at <u>12 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Gooch</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>8-26-61</u>	
PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>8-29-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis R. Wilson</u> ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 30 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

1

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

1925

Princess Anne, R.I.

Princess Anne, R.I.

Princess Anne, R.I.

Princess Anne, R.I.

Princess Anne, R.I.

Princess Anne, R.I.

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Princess Anne, R.I.

Princess Anne, R.I.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9656

09647

1. PLACE OF DEATH e. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>XX</b>				d. STREET ADDRESS <b>RFD</b>			
3. NAME OF DECEASED (Type or print) <b>Kate</b> <b>Bratten</b>				4. DATE OF DEATH <b>Aug. 11</b> <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 20, 1877</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>		IF UNDER 24 HRS. Hours <b>18</b> Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Bratten</b>				14. MOTHER'S MAIDEN NAME <b>Martha Bratten</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Reba Reddish Willards, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO <b>With cardiac failure.</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arterial occlusion of femoral artery.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>7/14/61</b> to <b>8/11/61</b> , 19 <b>61</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>8/11</b> , 19 <b>61</b> , and that death occurred at <b>3:45</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank E. Gantz Jr. M.D.</b>				22b. DATE SIGNED <b>8/11/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Frank E. Gantz Jr. M.D.</b>				22d. ADDRESS <b>5 Bay Street Berlin, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bratten Family</b>		23d. LOCATION (City, town or county) (State) <b>Willards, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley Sillyville</b>				25. REC'D BY REGISTRAR <b>15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Francis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3058

London

Alfred

XX

Rede

Female 11/10

Honourable

William Gordon

March 20, 1877

Own Home

London

Home London William

Frank E. Smith 11/10 1877

Alfred



9657

## CERTIFICATE OF DEATH

Reg. Dist. No. 09648

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>204 Linwood Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY Lee BRIGGS</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 14 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 3rd, 1879</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>7 11</u>		IF UNDER 24 HRS. <u>7 11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Bridgewater New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Harrison Briggs</u>				14. MOTHER'S MAIDEN NAME <u>Jane Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <u>Mrs Hena Hearn (Daughter) R.D. # 2 Parsonsburg, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>N/A 19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that I attended the deceased from <u>July 25, 1961</u> to <u>Aug 14, 1961</u> , that I last saw the deceased alive on <u>Aug 14, 1961</u> , and that death occurred at <u>9:55 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Camden Ave. Salisbury, Maryland</u> DATE SIGNED <u>Aug 15 / 1961</u>							
ACTUAL SIGNATURE <u>William D. Gray</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>				<u>Camden Ave. Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 17, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hammond Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HOLLOWAY &amp; COMPANY SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9658

CERTIFICATE OF DEATH

Reg. Dist. No. 19649

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		d. STREET ADDRESS <u>1800 Cooper Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Herbert J.</u> Middle <u>Chamberlain</u> Last <u>Chamberlain</u>		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 14 - 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>BENJAMIN CHAMBERLAIN</u>		14. MOTHER'S MAIDEN NAME <u>LAURA CHAMBERLAIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT Address <u>LAURA HICKMAN DAGSBORO, DEL.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure, severe ichthyosis, generalized arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-1</u> , 19 <u>61</u> , to <u>8-10</u> , 19 <u>61</u> ; that I last saw the deceased alive on <u>8-9</u> , 19 <u>61</u> , and that death occurred at <u>7:29 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert T. Adkins</u>		M.D. <u>FRUITLAND MARYLAND 10 Aug 61</u>	
PHYSICIAN'S NAME (Type) <u>Robert T. Adkins</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/12/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. GEORGES CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE, DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson &amp; May, Frankford, Del.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>AUG 14 '61</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

9659

09650

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Md.</b>				c. LENGTH OF STAY IN 1b <b>Since 6/27/61</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pine Bluff State Hospital</b>				d. STREET ADDRESS <b>Hurlock</b>			
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>-</b> Last <b>Conaway</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>12</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1891</b>	
				9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Waters</b>				14. MOTHER'S MAIDEN NAME <b>Mary Waters Mahaly Conaway</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>UnKnown</b>		17. INFORMANT <b>Records of Pine Bluff State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>002 X</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/27/ 1961</b> to <b>8/12/ 1961</b> , that (I) (we) last saw the deceased alive on <b>8/12/ 1961</b> , and that death occurred at <b>2p.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>E. P. Ritchings</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings</b>				22d. ADDRESS <b>Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 18, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Thompstontown Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Near East New Market, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Framptom and Son, Federalsburg, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 17 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9660											
Item 7 Film G293 8/18/61 mh											
09651											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>Route # 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Ernestine Marion Cottman</b>						4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 22-1908</b>		9. AGE (In years last birthday) <b>53 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>				11. BIRTHPLACE (County & State, or foreign country) <b>Freeland was Md</b>		12. CITIZEN OF WHAT COUNTRY? <b></b>	
13. FATHER'S NAME <b>Harry Cottman</b>				14. MOTHER'S MAIDEN NAME <b>Freeland was Md Addie Cottman</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b></b>				16. SOCIAL SECURITY NO. <b>918-20-8405</b>		17. INFORMANT <b>Seneca Williams Salisbury Md</b> Address <b>RFD</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca. of rectum with metastasis to liver</b> DUE TO <b>154X</b> Conditions, if any, which gave rise to immediate cause (b) <b></b> (e), stating the underlying cause last. (c) <b></b> DUE TO <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b></b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b>		(County) <b></b>		(State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>August 3</b> , 19 <b>61</b> to <b>August 9</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>August 9</b> , 19 <b>61</b> , and that death occurred at <b>9:55 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Juerman</b>				22b. DATE SIGNED <b>8/9/61</b>		22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>		22e. REC'D BY REGISTRAR <b></b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 12-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive</b>		23d. LOCATION (City, town or county) <b>Freeland Wic. Md</b>		(State) <b></b>		25b. REGISTRAR'S SIGNATURE <b>Charles H. Howard</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Howard</b>						25a. REC'D BY REGISTRAR <b></b>		25b. REGISTRAR'S SIGNATURE <b>Charles H. Howard</b>		DATE <b>AUG 15 '61</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09652

9661

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin RFD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NAMON</u> Middle <u>DASHFIELD</u> Last <u>NAMON</u>				4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/1897</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jesse Dashfield</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-6360</u>		17. INFORMANT <u>Eva Daxomis, N.Y., N.Y.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Strangulated right inguinal hernia</u> DUE TO (c) <u>unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>561.0</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>0</u> p. m. <u>0</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>White Haven, Md.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Phyllis A. Insley</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Phyllis A. Insley</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE HEREOF <u>8/20/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>White Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>White Haven, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Mossack, Director, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 21 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
DISEASE OR INJURY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM EXAMINATION		FINDINGS		REMARKS	
SIGNATURE OF NEXT OF KIN		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9662 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09702

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>✓</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Selbyville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route # 50</b>			d. STREET ADDRESS <b>R F D Box 234</b>		
3. NAME OF DECEASED (Type or print) <b>Reginald Clarence Davis</b>			4. DATE OF DEATH Month <b>8</b> Day <b>7</b> Year <b>61</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-19</b>		9. AGE (In years last birthday) <b>42</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>Fred J Davis</b>			14. MOTHER'S MAIDEN NAME <b>Jane M. Davis</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Jane M. Davis</b>			Address <b>Mappsville Va.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured cervical spine</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of truck that ran off the road and overturned.</b>		
20c. TIME OF INJURY Month, Day, Year <b>10 A.M. 8-7-61</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route # 50</b>		20f. (City or town) (County) (State) <b>Salisbury Wicomico Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>			DATE SIGNED <b>8-9-61</b>		
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/13/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Church</b>		22d. LOCATION (City, town, or country) (State) <b>Mappsville Va.</b>
23. FUNERAL DIRECTOR <b>Clinton F. Stewart</b>			24a. REC'D BY REGISTRAR <b>Salisbury Md.</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			DATE <b>AUG 11 '61</b>		

MEDICAL CERTIFICATION



MAILED  
JAN 11 1961

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Wisconsin

Salisbury

Route 450

D. Lawrence

Salisbury

P.O. Box 230

1-1-61

Reginald Lawrence Davis

1-1-61

Truck driver

Truck driver

Salisbury

Driver of truck that ran off the road and overturned.

10 M. 11-11-61 Route 450 Salisbury Wisconsin

1-1-61

107 Garden Ave. Salisbury, Md.  
D. L. Lawrence, M.D.



## CERTIFICATE OF DEATH

Reg. Dist. No. 09653

9663

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Worcester</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i> 2 3x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS <i>1177 Bellin St</i>			
3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>JAMES</i> Last <i>DENNIS</i>				4. DATE OF DEATH Month <i>August</i> Day <i>24</i> Year <i>1961</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 11 - 1893</i>	9. AGE (In years last birthday) <i>68 7/13</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Worcester Building</i>		11. BIRTH PLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James W. Dennis</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-30-3719</i>		INFORMANT <i>Mr. Hattie M. Dennis, Snow Hill, MD</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peritonitis</i> <i>S40.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Perforated gastric ulcer</i> (c) <i>Unknown</i>							INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/8</i> , 1961, to <i>8/24</i> , 1961, that I last saw the deceased alive on <i>8/24</i> , 1961, and that death occurred at <i>9:05 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>William H. H. J. M.D.</i>				ADDRESS (Street, city or town, state) <i>Salisbury, MD 21846</i>			
PHYSICIAN'S NAME (Type) <i>William H. H. J.</i>				DATE SIGNED <i>8-24-61</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Aug 27/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Catholic</i>		22d. LOCATION (City, town, or county) (State) <i>Snow Hill, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne E. Jones</i>				ADDRESS <i>Snow Hill, MD</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 28 '61</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>			

1. The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician. TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1868

(M)

*[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, age, date, and cause of death.]*

CERTIFICATE OF DEATH

Reg. Dist. No. 09654

5664

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> 19x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Blanche</u> First <u>H.</u> Middle <u>Dorsey</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20 1889</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Beauchamp</u>		14. MOTHER'S MAIDEN NAME <u>Melissa Pusey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs Robert Bradshaw</u>		Address <u>Cristfield Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerotic Heart Disease</u> DUE TO (c) <u>Leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-22-61</u> to <u>8-27-61</u> , that I last saw the deceased alive on <u>8-27</u> , 19 <u>61</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Goff</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>8-27-61</u>	
PHYSICIAN'S NAME (Type) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 29 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Quinton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Westover Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Harmon Frances Anne</u>		24a. REC'D BY REGISTRAR <u>SEP 5 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. House</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1904

1904



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9665

09655

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar (Rural)</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 3</b>		d. STREET ADDRESS <b>R.D.# 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First <b>MARTON</b>		Last <b>DOWNES</b>	
4. DATE OF DEATH <b>AUGUST</b>		Month <b>7th</b>		Day <b>19</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>April 21, 1883</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>16</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Timber Cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Timber</b>		11. BIRTHPLACE (State or foreign country) <b>Sussex Co. Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Joseph Downes</b>		14. MOTHER'S MAIDEN NAME <b>Sophia C. Melson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Mrs. Sarah E. Downes (Wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>420</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>Arteriosclerotic and hypertensive heart disease.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>5 yrs +</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20d. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> to <b>10/5</b> , that (I) (we) last saw the deceased alive on <b>8/5</b> 19 <b>61</b> , and that death occurred at <b>7:45 p.m.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Ernest M. Larmore</b>		22b. ADDRESS <b>Delmar, Delaware</b>		22c. DATE SIGNED <b>Aug. 8 / 1961</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 10, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Melson Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Melson, Maryland</b>		23e. REC'D BY REGISTRAR <b>AUG 9 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>					

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VS. A15ME  
5M 9/60



9667

## CERTIFICATE OF DEATH

Reg. Dist. No. 09657

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
**CO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pennsylvania General</u>				d. STREET ADDRESS <u>FRIENDSHIP RFD</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ISAAC HENRY Freeman</u>				4. DATE OF DEATH Month Day Year <u>August 15 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 9, 1899</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POULTRY FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>WHALEVILLE MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>LEVY FREEMAN</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA BRASURE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>N/A</u>			
17. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Asthma</u> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(Severe Pulmonary Emphysema)</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>David J. Schuone</u> M.D. <u>Salisbury Md. Aug. 15, 1961</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/17/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbox</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 18 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawe</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9668

## CERTIFICATE OF DEATH

09658

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>7 Mos. 29 Days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Agnes</u> Last <u>Gaines</u>				4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1882</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico - Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Way</u>				14. MOTHER'S MAIDEN NAME <u>Church</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Hospital Records - Salisbury, Maryland</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis - Multiple</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>18 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/20/60</u> , 19 <u>  </u> , to <u>8/18/61</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>8/18/61</u> , 19 <u>  </u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Lee L. Lawry</u>				M.D. <u>  </u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M.D.</u>				22d. ADDRESS <u>Deer's Head State Hospital - Salisbury</u>		22b. DATE SIGNED <u>7:15 P.M.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8/23/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Quantico</u>		23d. LOCATION (City, town or county) (State) <u>Quantico Md.</u>	
24. BUREAU DIRECTOR'S SIGNATURE <u>Arthur S. Stewart Salisbury Md</u>				ADDRESS		25a. REC'D BY REGISTRAR DATE <u>AUG 25 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Stewart</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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## CERTIFICATE OF DEATH

Reg. Dist. No. 119659

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>07X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>V</u> Last <u>Gonce</u>		4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1910</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ELWOOD BIRNEY</u>		14. MOTHER'S MAIDEN NAME <u>ELLA HAMILTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Robert W. Gonce</u>		Address <u>North East Md.</u>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Right Breast with</u> <u>170X</u> DUE TO <u>Metastases to Lung &amp; Adrenal</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Glands</u> DUE TO (c) <u>Approx 2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Approx 2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 31</u> , 19 <u>61</u> , to <u>8/4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8/4</u> , 19 <u>61</u> , and that death occurred at <u>4:30 p. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gidore</u>		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>8/4/61</u>	
PHYSICIAN'S NAME (Type) <u>Joseph R. Traub</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-7-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>North East Cecil Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Traub</u>		ADDRESS <u>North East Md</u>	
24a. REC'D BY REGISTRAR <u>AUG 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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9670

## CERTIFICATE OF DEATH

Reg. Dist. No. 09660

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Tyrone</u> Middle <u>Antonia</u> Last <u>Greene</u>		4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1961</u>
9. AGE (In years last birthday) <u>3</u>		10. IF UNDER 1 YEAR Months <u>22</u> Days <u>22</u> Hours <u>12</u> Min. <u>hrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Greene</u>		14. MOTHER'S MAIDEN NAME <u>Joan E. Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Albert Greene, Box 31, Sharptown, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> <u>045.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Shigella Dysentery</u> DUE TO (c) <u>approx 12 hrs.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/6</u> , 19 <u>61</u> , to <u>8/6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8/6</u> , 19 <u>61</u> , and that death occurred at <u>8:30</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred C. Koles</u> M.D. <u>Medical Center</u>		DATE SIGNED <u>8/7/61</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>August 9, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Zion Church Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Near Sharptown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Framptom and Son, Federalsburg, Maryland</u>		24a. REC'D BY REGISTRAR <u>August 11 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

208222.2 X45

CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 08661

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>1 721 Camden Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>ETHA</b> Middle <b>S.</b> Last <b>HEARN</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>14</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1898</b>
9. AGE (In years last birthday) <b>72</b>		10. IF UNDER 1 YEAR Month <b>11</b> Days <b>25</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Geo. Washington Smith</b>		14. MOTHER'S MAIDEN NAME <b>Mary Emma Hearn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. Anna W. Derickson (Sister) Camden Ave. City &amp; Mr. Harry M. Smith (Brother) Laurel, DEL.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinomatosis arising from breast</b> DUE TO (c) <b>Paralysis of both Cords (local) requiring tracheotomy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that I attended the deceased from <b>June 24, 1957</b> to <b>8/14, 1961</b> , that I last saw the deceased alive on <b>8/13, 1961</b> , and that death occurred at <b>2:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Pine Bluff Rd. Salisbury, Maryland</b> DATE SIGNED <b>Aug. 15/1961</b>			
ACTUAL SIGNATURE <b>Rufus S. Gardner Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. Rufus S. Gardner Jr</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 16, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olive Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>AUG 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hearn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MASSACHUSETTS DEPARTMENT OF HEALTH  
BOSTON, MASS.  
JANUARY 10, 1918  
TO THE  
HONORABLE  
COMMISSIONER OF HEALTH  
BOSTON, MASS.  
FROM  
THE  
SARATOGA SPRING  
HOTEL  
SARATOGA SPRING, N.Y.  
RE  
YOUR LETTER OF JANUARY 8, 1918  
RELATIVE TO THE  
CASE OF  
MR. J. H. BROWN  
OF  
BOSTON, MASS.  
WHO  
DIED  
AT  
SARATOGA SPRING, N.Y.  
ON  
JANUARY 7, 1918  
OF  
PNEUMONIA  
AND  
HEPATIC  
FAILURE  
I HAVE THE HONOR TO ACKNOWLEDGE  
YOUR LETTER AND TO INFORM YOU  
THAT THE  
CASE OF  
MR. J. H. BROWN  
HAS BEEN  
RECORDED  
IN THE  
DEPARTMENT OF HEALTH  
FILES  
AND  
THAT  
THE  
NECESSARY  
INVESTIGATION  
HAS BEEN  
MADE  
AND  
THAT  
THE  
CAUSE  
OF  
DEATH  
HAS BEEN  
DETERMINED  
TO BE  
PNEUMONIA  
AND  
HEPATIC  
FAILURE  
AS  
A  
RESULT  
OF  
THE  
ILLNESS  
WHICH  
HE  
SUFFERED  
FROM  
AT  
SARATOGA SPRING, N.Y.  
I AM, SIR, VERY RESPECTFULLY,  
YOUR OBLIGED SERVANT,  
J. H. BROWN

MASSACHUSETTS DEPARTMENT OF HEALTH  
BOSTON, MASS.  
JANUARY 10, 1918  
TO THE  
HONORABLE  
COMMISSIONER OF HEALTH  
BOSTON, MASS.  
FROM  
THE  
SARATOGA SPRING  
HOTEL  
SARATOGA SPRING, N.Y.  
RE  
YOUR LETTER OF JANUARY 8, 1918  
RELATIVE TO THE  
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ILLNESS  
WHICH  
HE  
SUFFERED  
FROM  
AT  
SARATOGA SPRING, N.Y.  
I AM, SIR, VERY RESPECTFULLY,  
YOUR OBLIGED SERVANT,  
J. H. BROWN



## CERTIFICATE OF DEATH

Reg. Dist. No. 09662

9672

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del</u> b. COUNTY <u>Dussay</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bronville E</u> First Middle Last				4. DATE OF DEATH <u>HEARN</u> Month <u>AUGUST</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-17-33</u>	
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Del</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Vernon Hearn</u>				14. MOTHER'S MAIDEN NAME <u>Alice Barton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-30-8853</u>		INFORMANT <u>Alice Hearn</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>322.1</u> DUE TO <u>Convulsions, Cause unknown.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic alcoholism</u> (c) <u>Pneumonia, Left Lower Lobe</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>?</u> <u>1 wk.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/11</u> 19 <u>61</u> to <u>8/13</u> 19 <u>61</u> , that I last saw the deceased alive on <u>8/12</u> 19 <u>61</u> and that death occurred at <u>3:38</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>ONELOFF ROAD</u> DATE SIGNED <u>8/13/61</u>			
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>				<u>SALISBURY, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-17-61</u>		<u>Delmar Cem</u>		<u>Delmar Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker McWest</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>AUG 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thompson</u>	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

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October 10

1902

Dear Sir

I have the honor

to acknowledge

the receipt of

your letter of

the 10th inst.

and in reply to

inform you that

the same has

been forwarded

to the proper

authorities for

their consideration.

I am, Sir, very

truly yours,

Wm. H. Smith

RECEIVED

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
9673  
CERTIFICATE OF DEATH  
09663

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARDELA</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WICOMICO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARDELA</u>	
c. LENGTH OF STAY IN 1b <u>60 yrs</u>		d. STREET ADDRESS <u>1 Bacon St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bacon St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HILARY A. HEATH</u> First Middle Last		4. DATE OF DEATH <u>Aug 31 1961</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 26 1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY HEATH</u>		14. MOTHER'S MAIDEN NAME <u>ALEVIA HORSEMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-10-8849</u>	
17. INFORMANT <u>MRS HELEN HEATH, MARDELA, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420 Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma, Stomach</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1961</u> to <u>31 Aug 1961</u> , that (I) (we) last saw the deceased alive on <u>31 Aug 1961</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>G. G. Schlesinger</u> M.D.		22b. DATE SIGNED <u>2 Sept 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George G. Schlesinger MD</u>		22d. ADDRESS <u>MARDELA, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-2-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MARDELA MEMORIAL</u>		23d. LOCATION (City, town, or county) (State) <u>MARDELA, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SMITH FUNERAL HOME, SHARPTOWN, MD</u>		25a. REC'D BY REGISTRAR <u>SEP 6 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

64008

CELESTINE DE BATH

0153

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## CERTIFICATE OF DEATH

Reg. Dist. No.

09664

9674

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMACK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN lb <u>3 1/2 MOS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING HILLS SANITORIUM</u>		d. STREET ADDRESS <u>ROUTE #50</u>	
3. NAME OF DECEASED (Type or print) First <u>ALGERNON</u> Middle <u>THOMAS</u> Last <u>HICKMAN</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 27, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HARDWARE (OWNER)</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM T. HICKMAN</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA LILLISTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>MILTON T. HICKMAN</u> Address <u>PAINTER, VIRGINIA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>CEREBRAL ARTERIOSCLEROSIS</u> (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>CEREBRAL ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS.</u> <u>YRS.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONTACT DERMATITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/8</u> , 19 <u>61</u> , to <u>8/8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8/3</u> , 19 <u>61</u> , and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>PINEBLUFF ROAD</u> DATE SIGNED <u>8/8/61</u> ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D. <u>SALISBURY, Md</u> PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/10/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKSLEY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PARKSLEY, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Williams</u> ADDRESS <u>WILLIAMS FUNERAL HOME ONANOCK, VA.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 10 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Funn</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9675

09665

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY in 1b <b>14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>207 High Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Edna Jordan Hirst</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>7</b> Year <b>19 61</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>11/10/1875</b>	
<b>9. AGE</b> (In years last birthday) <b>85</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>9</b>		<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Housewife</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>William Jordan</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah <del>Hirst</del> Woolford</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>No</b>		<b>17. INFORMANT</b> <b>Mr. Edwin Hirst, Trappe, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)</b> <b>Acute myocardial failure</b> <b>7-20-0</b> <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>DUE TO (b)</b> <b>Arteriosclerotic heart disease</b> <b>DUE TO (c)</b> <b>Arteriosclerosis, general</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>48 hrs</b> <b>Years</b> <b>Years</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Fracture of right femur</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from July 24, 1961, to August 7, 1961, that (I) (we) last saw the deceased alive on August 7, 1961, and that death occurred at 4:45 A.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>L. V. Maldve, M. D.</b>				<b>22b. DATE SIGNED</b> <b>8/7/61</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>L. V. Maldve, M. D.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>8/9/1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Christ Church Cemetery</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Le Compte Funeral Service, Cambridge, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE AUG 9 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>	

VR A15 (4)  
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*L. V. ...*

to George ...  
Cambridge, Md.

United Church ...

Mr. Edwin ...

William ...

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Female ...

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9676

Item 9 Film 0293

09666

1. PLACE OF DEATH a. COUNTY <b>WICOMICO</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING HILL NURSING HOME</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WICOMICO</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X MARDELLA</b> d. STREET ADDRESS <b>MAIN ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMMA BRATTAN HITCH</b>			4. DATE OF DEATH Month Day Year <b>AUG 10 1961</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/13/76</b>	9. AGE (In years last birthday) <b>84</b>	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		
10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOSEPH BRATTAN</b>			14. MOTHER'S MAIDEN NAME <b>SUSAN ROBERTSON</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		
17. INFORMANT <b>S.G.L. HITCH, 117 CRESCENT HILL RD</b>			Address <b>PITTSFORD, N.Y.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CARCINOMA OF BREAST</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/21</b> to <b>8/10</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/3</b> , 19 <b>61</b> , and that death occurred at <b>8:57</b> A.M., from the causes and on the date stated above.					
22a. SIGNATURE <b>Rufus S. Gardner Jr.</b> M.D.			22b. DATE SIGNED <b>8/10/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>RUFUS S. GARDNER, JR.</b>			22d. ADDRESS <b>PINEBLUFF RD, SALISBURY, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>8/14/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MARDELLA CEMETERY</b>	
23d. LOCATION (City, town or county)		23e. (State)		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HILL &amp; JOHNSON</b>		ADDRESS <b>SALISBURY, MD.</b>		25a. REC'D BY REGISTRAR <b>AUG 16 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

9677

09667

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARBLEDA</u>				c. LENGTH OF STAY IN 1b <u>4 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAPLESHADE NUR. HOME</u>				d. STREET ADDRESS <u>1 PEMBERTON DR. RT 3</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SALLY</u> Middle <u>HENRY</u> Last <u>HUMPHREYS</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 17, 1885</u>	
9. AGE (In years, months, and days) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ISAAC J. HENRY</u>				14. MOTHER'S MARDEN NAME <u>MARY E. HEARN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ELIZ. H. REMINGTON-LAUREL, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arterio Sclerosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerotic Heart-Mitral Regurgitation</u> DUE TO (c) <u>Sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 11, 1961</u> to <u>Aug 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 5, 1961</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>H. S. Kuhlman</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>H. S. Kuhlman</u>				22d. ADDRESS <u>Shurpton Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8/8/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SALISBURY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HILL &amp; JOHNSON CO., SALISBURY, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Finner</u>	

(M)

2077

EXHIBIT OF BLACK

ALABAMA STATE DEPARTMENT OF HEALTH  
BIRMINGHAM, ALABAMA

TO THE HONORABLE  
COMMISSIONER OF HEALTH  
BIRMINGHAM, ALABAMA

FROM: [illegible]  
DATE: [illegible]

SUBJECT: [illegible]

[illegible text follows]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9678											
CERTIFICATE OF DEATH											
09668											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY in 1b <b>46 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Salisbury</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>					d. STREET ADDRESS <b>19 X-2</b>						
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Ingersoll</b> Last <b>Ingersoll</b>					4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>19 61</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1872</b>		9. AGE (In years last birthday) <b>89</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Somerset, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>James Ingersoll</b>					14. MOTHER'S MAIDEN NAME <b>Angeline Smullen</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO.					17. INFORMANT Address <b>Evelyn Gibbons: RFD #1 Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>450-0</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>e.m.</b> Month, Day, Year <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>June 26</b> , 19 <b>61</b> to <b>August 11</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>August 11</b> , 19 <b>61</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Lee L. Lawry</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/11/61</b>				
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M. D.</b>					22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Allen Methodist</b>		23d. LOCATION (City, town or county) (State) <b>Allen, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>James Herman</b>					ADDRESS <b>Princess Anne, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

(M)

2978

2978

Salisbury no age

Don't read State Hospital

x

Salisbury no age

June 28, 1898 87

Farmer U.S.

James Ingraham

Angeline Smullen  
Averyn Gibson: WPA Salisbury, Md.

June 20 of August 11 61

11:30 A.M.

Salisbury

Lee H. Smith, Jr. 11  
Don't read Salisbury, Md.

Buried 6/13/61 Allen & Corbett Allen, Maryland

Trinooz Anne, Md. 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

119707

9679

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pahisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CULLEN SIMMONS JENKINS</u>				4. DATE OF DEATH Month Day Year <u>August 6 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22, 1907</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CANNER REALTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>		11. BIRTHPLACE (State or foreign country) <u>CAMBRIDGE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH JENKINS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH SIMMONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT Address <u>MR. C.R. JENKINS, MILFORD DEL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 29</u> , 19 <u>61</u> , to <u>Aug. 6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>61</u> , and that death occurred at <u>5:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Schumore</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Aug. 6, 1961</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/9/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. Burboye</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>AUG 9 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(M)

1978

CERTIFICATE OF DEATH

(C)

Mr. C. B. Jenkins, Plaintiff  
vs.  
Mrs. W. Jenkins, Defendant  
Case No. 12345  
County of ... State of ...  
The undersigned, being duly sworn, depose and say that the within and foregoing is a true and correct copy of the original as the same appears from the records of the Court in the above entitled case.

Subscribed and sworn to before me this ... day of ... 1978.  
Notary Public for the State of ...  
My commission expires on ...

Witness my hand and seal this ... day of ... 1978.  
Notary Public for the State of ...

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9680

## CERTIFICATE OF DEATH

09669

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Port Deposit, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>6yrs 17 days</b>		d. STREET ADDRESS <b>Route #1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bell</b> Middle <b>F.</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>6</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 22, 1903</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b>	IF UNDER 24 HRS. Hours <b>58</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNKNOWN</b>	
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MANLEY H. JONES, PORT DEPOSIT, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b> (c) <b>Arteriosclerosis, general</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>Years</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 20, 1955</b> to <b>Aug. 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 6, 1961</b> , and that death occurred at <b>7:00 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Maldve, M.D.</b>		22b. DATE SIGNED <b>Aug. 6, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Maldve, M.D.</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/9/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Port Deposit, Md.</b>
24 FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M Reed, Rising Sun, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 9 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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639

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**1**  
**FOR STATE**  
**HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if necessary, by the attending physician, or by the coroner, or by the funeral director. Page 1, 2, and 3 to be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**M**

**I**

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
08670									
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WHITE HAVEN</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Wico.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FRUITLAND</b> d. STREET ADDRESS <b>1 Clyde Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Maudie Esham Kenney</b>					4. DATE OF DEATH Month <b>8</b> Day <b>13</b> Year <b>1961</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 14 1913</b>		9. AGE (In years last birthday) <b>48</b> IF UNDER 1 YEAR: Months <b>4</b> Days <b>8</b> IF UNDER 24 HRS.: Hours <b>4</b> Min. <b>48</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ERNEST ESHAM</b>					14. MOTHER'S MAIDEN NAME <b>BELLE FREEMAN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>H. D. KENNEY - SAME</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO <b>850X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>850X</b> DUE TO (c) <b>850X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>850X</b> INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall from Bow of Small Boat</b>						
20c. TIME OF INJURY Month, Day, Year <b>3:30 a.m. 8/13/61</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Ellis Bay</b>		20f. (City or town) <b>Wicomico</b> (County) <b>Wicomico</b> (State) <b>MD</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Earl L. Royer</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Earl L. Royer</b>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					Address (Street, city, town, or county) <b>8-14-61</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			22b. DATE THEREOF <b>8/16/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>		22d. LOCATION (City, town, or country) (State) <b>SALISBURY, MD.</b>		
23. FUNERAL DIRECTOR <b>HILL &amp; JOHNSON CO. SALISBURY, MD.</b>					24a. REC'D BY REGISTRAR <b>AUG 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9682

## CERTIFICATE OF DEATH

Reg. Dist. No.

09671

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>19x-2</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springhill Sanitarium</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> d. STREET ADDRESS <b>19x-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rose Lankford Krause</b>		4. DATE OF DEATH Month Day Year <b>Aug. 24 19 61</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 9, 1876</b>
9. AGE (In years last birthday) <b>85</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Lankford</b>		14. MOTHER'S MAIDEN NAME <b>Michael Bailey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Charles Hayman Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>151x</b> DUE TO (c) <b>151x</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/10</b> , 19 <b>59</b> , to <b>8/24</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Aug 24</b> , 19 <b>61</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>David J. Gibson</b> M.D. <b>Salisbury Md</b> DATE SIGNED <b>Aug 25, 1961</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-27-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Antioch Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Wilson</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 30 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1952

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TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9683

Item 2 Film Q294

9/7/61 ink

09672

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wico.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>307 N. BLVD.</u>		d. STREET ADDRESS <u>1307 N. DUNBLOW BLVD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carinne</u> Middle <u>Fass</u> Last <u>Liebman</u>		4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 20, 1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIMON FOSS</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA JACOBOSKY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>JULIUS N. LIEBMAN, SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.2</u> DUE TO <u>Cardiac Degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> 19 <u>54</u> to <u>8/30/61</u> 19 <u>61</u> , that (I) (we) lost the deceased alive on <u>8/29/61</u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>C. E. Mitchell</u>		22b. DATE SIGNED <u>8/30/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/30/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ahaveth Israel</u>		23d. LOCATION (City, town, or county) (State) <u>Norfolk, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u>		25a. REC'D BY REGISTRAR <u>SEP 1 '61</u>	
ADDRESS <u>SALISBURY, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kross</u>	

53



9684

09673

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Mardela</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maple Shade nursing home</u>				d. STREET ADDRESS <u>1 Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Norman Wiser Lord</u>				<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>16</u> , Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1878</u>		9. AGE (In years last birthday) yrs. <u>83</u>	
				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James W. Lord</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. 		17. INFORMANT Address <u>Mrs. Bertie Wheatley, Laurel, Dela.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> <u>151X</u> DUE TO Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio Sclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>8 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 16, 1961</u> to <u>Aug 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 16, 1961</u> , and that death occurred <u>AP</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>H. S. Kuhlman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. S. Kuhlman</u>				22d. ADDRESS <u>Sharptown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Galestown</u>		23d. LOCATION (City, town, or county) (State) <u>Galestown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home</u>				ADDRESS <u>Sharptown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 22 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

**O HOSPITAL (continued):** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**O FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

BIRTH

DEATH

INTERVIEW

TESTIMONY

VERIFICATION

SIGNATURE

WITNESS

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SEARCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9685 CERTIFICATE OF DEATH 08674											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>114 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>Route # 4</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Luvenia</b> Middle <b>Matthews</b> Last <b>Matthews</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>19 61</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 12, 1882</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>27</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Josaha P. Smullen</b>						14. MOTHER'S MAIDEN NAME <b>Martha A. Tarr</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs. Lena Heller (Daughter) 1139 Dorchester Ave. Baltimore 7, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerosis, general</b>										INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>No contributing</b>											
20a. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) <b>Salisbury</b> (County) <b>Wicomico</b> (State) <b>Md.</b>		20e. (City or town) <b>Salisbury</b> (County) <b>Wicomico</b> (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 17, 1961</b> to <b>August 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 9, 1961</b> , and that death occurred at <b>11:40 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>L. V. Maldve, M. D.</b>				22b. DATE SIGNED <b>8/10/61</b>		22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Aug. 12, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smullen Cemetery R.D. # Salisbury, Maryland</b>		23d. LOCATION (City, town or county) <b>Salisbury, Maryland</b> (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR <b>AUG 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

M

HOLLAND & COMPANY SALTSBURY MARYLAND

WILLIAM H. HOLLAND, President

WILLIAM H. HOLLAND, Secretary

WILLIAM H. HOLLAND, Treasurer

WILLIAM H. HOLLAND, Director

WILLIAM H. HOLLAND, Director

WILLIAM H. HOLLAND, Director

WILLIAM H. HOLLAND, Director

WILLIAM H. HOLLAND, Director

WILLIAM H. HOLLAND, Director

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WILLIAM H. HOLLAND, Director

WILLIAM H. HOLLAND, Director

WILLIAM H. HOLLAND, Director

WILLIAM H. HOLLAND, Director

WILLIAM H. HOLLAND, Director

WILLIAM H. HOLLAND, Director

## CERTIFICATE OF DEATH

Reg. Dist. No. 09675

9685

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>7 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>R.F.D. 1</u>			
3. NAME OF DECEASED (Type or print) First <u>LLOYD</u> Middle <u>P.</u> Last <u>McDANIEL</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 31, 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOHN H. McDANIEL</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH PARSONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-16-1973</u>			
17. INFORMANT <u>MRS DOROTHY M. GIBBONS, DOVER, DEL.</u>				Address <u>DOVER, DEL.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prothrombin Defect</u> 450.0 DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Partial obstruction - Coronary artery and blood</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8:23</u> , 19 <u>61</u> , to <u>8:30</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8:30</u> , 19 <u>61</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. A. Briele</u>				ADDRESS (Street, city or town, state) <u>Salisbury Md</u>			
PHYSICIAN'S NAME (Type) <u>H. A. Briele</u>				DATE SIGNED <u>9/1/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-2-61</u>		22c. NAME OF CEMETERY <u>PRESBYTERIAN</u>		22d. LOCATION (City, town, or county) (State) <u>REHOBOTH, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>				ADDRESS <u>Pocomoke City, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 5 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

28

DECEASED

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
9687  
96876  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JEROME</b> Middle <b>COULTER</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>6th</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1937</b>
9. AGE (In years lost birthday) <b>24</b> yrs.		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>24</b> Hours <b>24</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service-man Sears Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Employee</b>	
11. BIRTHPLACE (State or foreign country) <b>Mt Vernon New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Edwin D. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Marie V. Coulter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Mrs. Barbara L. Miller (Wife)</b>		Address <b>1519 S. Div. St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanoma - Brain (metastatic)</b> <b>190.5</b> DUE TO <b>Melanoma of Bowel</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>190.5</b> DUE TO <b>Melanoma of Bowel</b> (c) <b>190.5</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>190.5</b> INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>year</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>6-27-1957</b> to <b>8-6-1961</b> that (I) (we) last saw the deceased alive on <b>8-6-1961</b> , and that death occurred on <b>8-6-1961</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl L. Royer</b>		22b. DATE SIGNED <b>Aug. 8 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer</b>		22d. ADDRESS <b>407 Camden Ave. Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 9, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY, MARYLAND</b>	
25a. REC'D BY REGISTRAR <b>AUG 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

1920

(Signature) (Name) (Address) (City) (State) (Country)

1920

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **09677**

9688

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Del.</b> b. COUNTY <b>SUSSEX</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HARRY</b> First Middle Last <b>Moore</b>				4. DATE OF DEATH <b>August 1 1961</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-24-10</b>	
9. AGE (In years lost birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Baldwin Moore</b>				14. MOTHER'S MAIDEN NAME <b>Martha Donaway</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>#2 222-01-4088</b>		INFORMANT <b>Jessie Lee Moore</b>		Address <b>Millsboro Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7:31</b> , 19 <b>61</b> , to <b>8:1</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>7:31</b> , 19 <b>61</b> , and that death occurred at <b>12:28</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. A. Briele</b>		ADDRESS (Street, city or town, state) <b>Medical Center Salisbury Md</b> DATE SIGNED <b>8-1-61</b>					
PHYSICIAN'S NAME (Type) <b>H. A. Briele</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/4/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mechanics Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Millsboro Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Watson &amp; Gray</b>				ADDRESS <b>Millsboro, Del.</b>		24a. REC'D BY REGISTRAR <b>AUG 9 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

(M)

to the

W. F. Drake

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FOR STATE HEALTH DEPT. M  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if necessary, by the funeral director, in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT. M  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if necessary, by the funeral director, in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D.O.A. Pen Gen Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>108 W. Lehigh Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>CARDIA</b>		First <b>IZETTA</b>		Middle <b>OLIPHANT</b>		Last <b>OLIPHANT</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>14</b> Year <b>61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 21, 1897</b>		9. AGE (In years last birthday) <b>64</b> yrs. IF UNDER 1 YEAR: Months <b>6</b> Days <b>14</b> IF UNDER 24 HRS.: Hours <b>14</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Nanticoke, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Alphious Rencher</b>				14. MOTHER'S MAIDEN NAME <b>Anna S. Robertson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>				17. INFORMANT <b>Mr Charles M. Oliphant (Husband)</b> Address <b>108 West Lehigh Ave. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullet wound of Brain</b> DUE TO <b>976</b> Conditions, if any, which gave rise to immediate cause (b) (c) <b>Sudden</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Self inflicted rifle wound</b>					
20c. TIME OF INJURY Month, Day, Year <b>3:45 p.m. 8/14/61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Salisbury</b>		(County) <b>Wicomico</b>	
								(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>Aug. 15 / 1961</b>	
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 18, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or country) <b>Salisbury, Maryland</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>AUG 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, any delay should be noted in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9690 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09679											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsburg</b> c. LENGTH OF STAY IN 1b <b>11 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsburg</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Frederick Isaac Parsons</b>				4. DATE OF DEATH Month <b>8</b> Day <b>8</b> Year <b>1961</b>							
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-26-1890</b>		9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic-retired. Automobile</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Isaac W. Parsons</b>				14. MOTHER'S MAIDEN NAME <b>Mary Catherine Parsons</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>166-16-1547</b>				17. INFORMANT <b>Mrs. Frederick Parsons, Parsonsburg, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of right lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>		DATE SIGNED <b>8-10-61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsonsburg Cemetery</b>		22d. LOCATION (City, town, or country) <b>Parsonsburg Wicomico Md.</b>		23. FUNERAL DIRECTOR <b>Hill and Johnson Funeral Home, Salisbury, Md.</b>			
				24a. REC'D BY REGISTRAR <b>AUG 14 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>					

FOR MEDICAL EXAMINERS CERTIFICATE OF DEATH

Albany, New York  
Personnel  
11-1-1930

Personnel  
1-28-1930

Personnel  
1-28-1930  
Personnel  
1-28-1930

Personnel  
1-28-1930

Personnel  
1-28-1930  
Personnel  
1-28-1930

9691

## CERTIFICATE OF DEATH

Reg. Dist. No.

09680

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> d. STREET ADDRESS <u>Somerset Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>I. Fred</u> <u>Phoebus</u> 4. DATE OF DEATH Month Day Year <u>August 29</u> <u>1961</u>				5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 14 1877</u> 9. AGE (In years lost birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u> 11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Henry B. Phoebus</u> 14. MOTHER'S MAIDEN NAME <u>Emily Willing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>INFORMANT</u> <u>Margaret Dryden</u> Address <u>Somerset Ave Princess Anne</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from colon</u> DUE TO <u>Diverticulitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Aortic aneurysm</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat white <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>8:27</u> , 19 <u>61</u> , to <u>8:29</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8:29</u> , 19 <u>61</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. A. Briele</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 22b. DATE THEREOF <u>Sept 1, 1961</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Manokin Presbyterian</u> 22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md.</u>				ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>8:29.61</u>			
PHYSICIAN'S NAME (Type) <u>H. A. Briele</u> <u>Salisbury Md</u> 24a. REC'D BY REGISTRAR <u>SEP 5 '61</u> 24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>James Harmon</u> ADDRESS <u>Princess Anne Md</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wm. A. ...

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9692

09681

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>2533 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Worcester</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> d. STREET ADDRESS <u>R.F.D. 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Emile Franklin Pickhardt</u>		<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>21</u> Year <u>19 61</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec. 12, 1897</u>		<b>9. AGE</b> (In years last birthday) <u>63</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>United States (Conn.)</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Gustavus William Pickhardt</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Louisa Schneider</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>218-24-3848</u>		<b>17. INFORMANT</b> <u>Mrs Cora M. Pickhardt, Maryland</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial failure</u> DUE TO (b) <u>Familial muscular dystrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>  <u>26 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Sept. 11, 1954</u> to <u>Aug. 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 21, 1961</u> , and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Lee L. Lawry</u> M.D.			<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Aug. 21, 1961</u>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Lee L. Lawry, M. D.</u>			<b>22d. ADDRESS</b> <u>Deer's Head State Hospital, Salisbury, Maryland</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>8-24-61</u>		<b>23c. NAME OF CEMETERY</b> <u>Presbyterian</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Pocomoke City, Maryland</u>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert H. Watson</u>			<b>ADDRESS</b> <u>Pocomoke City, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 25 '61</u>		
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hays</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined and signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9694											
CERTIFICATE OF DEATH											
09683											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester, Maryland</u> d. STREET ADDRESS <u>17X-2</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>						c. LENGTH OF STAY IN 1b <u>1yr. 9mo. 1day</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Wheatley</u> Last <u>Reid</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>19</u> Year <u>1961</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5, 1900</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LA Borer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>214-90-3473</u>		17. INFORMANT <u>  </u>		Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (e), stating the underlying cause last. DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 18</u> , 19 <u>59</u> to <u>Aug. 19</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug. 19</u> , 19 <u>61</u> , and that death occurred at <u>8:20PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Lee L. Laury</u>				M.D. <u>  </u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Aug. 19, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lee L. Laury, M.D.</u>				22d. ADDRESS <u>Salisbury, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-23-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chester</u>		23d. LOCATION (City, town or county) <u>Chester</u>		(State) <u>md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Shnell, Porton, Md.</u>				ADDRESS <u>  </u>		25a. REC'D BY REGISTRAR DATE <u>AUG 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>			

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## CERTIFICATE OF DEATH

Reg. Dist. No. 9685

9696

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>1 DAY</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> d. STREET ADDRESS <u>19X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>ROTH</u> Last <u>ROTH</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>— — 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FORMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIGAR MFG.</u>	
11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL ROTH</u>		14. MOTHER'S MAIDEN NAME <u>SEREL (UNK.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Anne Schwartz 4929 N. Granbuck</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>unbroken</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-23-1961</u> to <u>8-23-1961</u> that I last saw the deceased alive on <u>8-23-1961</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William B. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>8-23-61</u>	
PHYSICIAN'S NAME (Type) <u>WILBUR R. ELLIS, JR</u>		<u>SALISBURY, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/19/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Montefiore</u>		22d. LOCATION (City, town, or county) (State) <u>Mont Co. Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HILL &amp; JOHNSON</u> ADDRESS <u>SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR <u>Aug 25 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9697

## CERTIFICATE OF DEATH

Reg. Dist. No. 18686

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George William Sattler</u>				4. DATE OF DEATH Month Day Year <u>August 17 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-18-1888</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Omaha Nebraska</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Herman Sattler</u>				14. MOTHER'S MAIDEN NAME <u>Louise Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		INFORMANT <u>Alice W. Sattler</u>		Address <u>Monkton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>420</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/14</u> , 19 <u>61</u> , to <u>8/17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Aug 17</u> , 19 <u>61</u> , and that death occurred at <u>8:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u>				ADDRESS (Street, city or town, state) <u>Salisbury Md.</u>			
PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE</u>				DATE SIGNED <u>Aug. 17, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-18-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Epis</u>		22d. LOCATION (City, town, or county) (State) <u>Old York Rd Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service Towson Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 22 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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Frederick Funeral Service Bureau Inc.

Burial 8-18-61 St. James Epis

Old York Rd

Frederick

THOMAS T. C. W. 1961

Funeral Service Bureau Inc.  
Frederick, Md.

No

Farman Sallier

Louise Johnson

Farmer

Farmer

Carroll Johnson

U.S.A.

11-18-1958

72

Monkton, Maryland

Monkton

Maryland

Baltimore

CERTIFICATE OF DEATH

1957

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

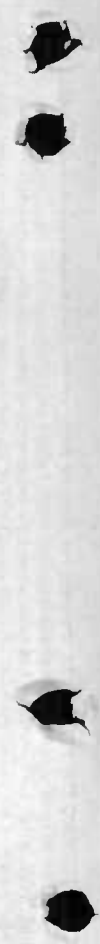
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
9698 CERTIFICATE OF DEATH 09687

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>RICHARD</b> Last <b>SHOCKLEY</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>29th</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1921</b>	9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>15</b>	IF UNDER 24 HRS. Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer (Employee)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Preston E. Shockley</b>				14. MOTHER'S MAIDEN NAME <b>Mary C. Polliard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES W.W.#II</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Elizabeth Shockley (Wife)</b> Address <b>102 Sylvia St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>1420</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>5 days</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>8-24</b> to <b>8-29</b> , that (I) (we) last saw the deceased alive on <b>8-29</b> 19 <b>61</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Earl L. Royer</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Aug. 31 /1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer</b>				22d. ADDRESS <b>407 Camden Ave., Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 9/1/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memory Gardens-</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY MARYLAND</b>		25a. REC'D BY REGISTRAR <b>SEP 5 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

1900

17





1  
FOR STATE  
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If delay is necessary, the funeral director, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 9/60

STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9699 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09688

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D.# (On Farm)(Field)</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b> d. STREET ADDRESS <b>R.D.# 3 (Walston)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>THOMAS VICTOR SMALLWOOD</b>			4. DATE OF DEATH <b>AUGUST 7th 1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1907</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee-Nursery</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nurseryman</b>	11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Walter Smallwood</b>			14. MOTHER'S MAIDEN NAME <b>Addie Kelly</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT (Address) <b>Mrs. Lucy E. Smallwood (Wife) R.D.# 3 Walston Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause parting for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>8-7</b> 19 <b>61</b> p.m.	2Dd. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Wicomico Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type)		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Aug. 8 / 1961</b>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 9, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	
22d. LOCATION (City, town, or country) (State) <b>Salisbury, Maryland</b>		23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>			
24a. REC'D BY REGISTRAR <b>AUG 10 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>			

MEDICAL CERTIFICATION

THE NEW  
SPRINGFIELD

1914

1914

THE NEW  
SPRINGFIELD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9700

STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09689

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wico.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1wk.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X EDEN</u>		d. STREET ADDRESS <u>Rte # 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PEN GEN Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BEULAH</u> First <u>COOPER</u> Middle <u>STOUT</u> Last		4. DATE OF DEATH <u>8</u> Month <u>20</u> Day <u>1961</u> Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 9, 1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM H. COOPER</u>		14. MOTHER'S M maiden NAME <u>ISABELLA HARCUM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>JOHN W. STOUT</u> Address <u>- SAME</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Uremia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>3 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>59</u> to <u>Aug 20</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 20</u> 19 <u>61</u> , and that death occurred at <u>2:10 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>B. Frank Giganti</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>		22d. ADDRESS <u>PRINCESS ANNE Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/23/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MANORIN CEMET.</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCESS ANNE MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HILL &amp; JOHNSON</u> ADDRESS <u>SALISBURY, MD.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>AUG 23 '61</u>	
25b. REGISTRAR'S SIGNATURE			

BP





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Winnipeg General Hospital

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9702

## CERTIFICATE OF DEATH

Item 9 Film 0293 8/23/61 mh

09691

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;"><u>MARYLAND</u></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN It <u>4 Mos. 20 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;"><u>Wicomico</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Route #1 -- Union Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Saunders</u> First Middle Last <u>Taylor</u>				<b>4. DATE OF DEATH</b> <u>August 10 19 61</u>			
5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 12, 1882</u> <u>78</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>		9. AGE (In Years IF UNDER 1 YEAR IF UNDER 24 HRS.) last birthday Months Days Hours Min.			
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>West Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Honoritta Price</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Hospital Records --- Salisbury, Maryland</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>3/23/61</u> , 19 <u>61</u> , to <u>8/10/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/10/61</u> , 19 <u>61</u> , and that death occurred at <u>6:PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Lee L. Lawry, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M.D.</u>				22b. DATE SIGNED <u>7 55</u>			
22d. ADDRESS <u>Deer's Head State Hospital -- Salisbury</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>8/15/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Fruitland, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley, Salisbury, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 17 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

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(T)

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2700

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## CERTIFICATE OF DEATH

Reg. Dist. No.

08692

9703

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>318 Short St. 2nd fl.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Baby Boy Thomas</u>				4. DATE OF DEATH <u>August 15 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/15/61</u>	
9. AGE (In years lost birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>32</u> Days <u>32</u>		IF UNDER 24 HRS. Hours <u>32</u> Min. <u>32</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Victor Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Ginn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>Victor Thomas 318 Short St. Pocomoke Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - 22 who ill</u> DUE TO <u>second born twin</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Cause of prematurity unknown</u> (b) <u>second born twin</u> (c) <u>Cause of prematurity unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2hr 32min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/15/61</u> , 19 <u>61</u> , to <u>8/15/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8/15/61</u> , 19 <u>61</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Cohen</u>				ADDRESS (Street, city or town, state) <u>318 Short St. Pocomoke Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edgar K. Horton - new church, Va.</u>				DATE <u>8/16/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Johnson Neck Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar K. Horton - new church, Va.</u>				24a. REC'D BY REGISTRAR <u>AUG 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

22 22 335 XVO

I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of New York, do hereby certify that  
 the within and foregoing is a true and correct copy of the original record of the death of  
 the person named therein, as the same appears from the records of the Department of Health, City and County of New York.  
 In testimony whereof, I have hereunto set my hand and the seal of the Department of Health, at New York, this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.  
 \_\_\_\_\_  
 Medical Officer of Health

9704

CERTIFICATE OF DEATH

Reg. Dist. No. 09693

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>318 Short St</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u>		4. DATE OF DEATH <u>August 16 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 15, 1961</u>
9. AGE (In years lost birthday) <u>10</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Victor Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Ginn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Victor Thomas 318 Short St. Pocomoke Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - 22 wks - 1 lb</u> DUE TO (b) <u>first born twin</u> DUE TO (c) <u>cause of prematurity unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 hr 5 min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/15/61</u> , 19 <u>61</u> , to <u>8/16/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8/16/61</u> , 19 <u>61</u> , and that death occurred at <u>5:57 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Cohen</u>		ADDRESS (Street, city or town, state) <u>Iron Hill Md</u>	
PHYSICIAN'S NAME (Type) <u>Edgar W. Horton</u>		DATE <u>AUG 21 '61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Johnson Neck Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar W. Horton - new church, Va.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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*[Faint, mostly illegible handwritten text, likely a death certificate form. The text is mirrored across the page, suggesting bleed-through from the reverse side.]*



9705

## CERTIFICATE OF DEATH

Reg. Dist. No. 19694

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>2 Month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>19X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie Thomas HARRIS</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 2 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/16/1894</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Seacon Work</u>		11. BIRTHPLACE (State or foreign country) <u>Monticello, Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>							
13. FATHER'S NAME <u>Asbury Kitchen</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Barber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				INFORMANT Address <u>Carrie Lawson Deerfield Beach, Fla.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO <u>Renal Disease</u> (c)							
INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 yrs.</u> <u>1 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 22, 1961</u> to <u>Aug 2, 1961</u> , that I last saw the deceased alive on <u>Aug 2, 1961</u> , and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. Frank Giganti</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>20 Prince William St Prince Anne, Md</u> <u>8/9/61</u>			
PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/11/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>First Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Deerfield Beach, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr. Princess Anne, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 8 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, it may be delayed. It is necessary, however, to file this certificate with the funeral director, page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

9706 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03695

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D.# 1 (Shad Point)</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b> d. STREET ADDRESS <b>R.D.# 1 (Shad Point)</b>	
3. NAME OF DECEASED (Type or print) <b>ROBERT GERALD TOWNSEND</b>		4. DATE OF DEATH Month <b>August</b> Day <b>19th</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 27, 1950</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School boy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>11</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert Fulton Townsend (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Louise Disharoon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Louise D. Townsend (Mother)</b>		Address <b>R.D.# 1 Shad Point - Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullet wound of heart</b> 919.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Beating bushes with gun and gun went off.</b>	
20c. TIME OF INJURY Month, Day, Year <b>4</b> Hour <b>8/19/61</b> a.m. <b>p.m.</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>	20f. City or town (County) (State) <b>R.D.# Salisbury (Wico.) Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b> EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>		DATE SIGNED <b>August 21/1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 23, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Shad Point Cemetery - R.D.# Salisbury, Maryland</b>	22d. LOCATION (City, town, or country) (State)
23. FUNERAL DIRECTOR <b>HOILLOWAY &amp; COMPANY SALISBURY MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>AUG 24 '61</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9707

09696

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fredericktown</b> d. STREET ADDRESS <b>07X-2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Adrienne</b> Middle <b>Louise</b> Last <b>Tuch</b>			<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>2</b> Year <b>19 61</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>May 9, 1907</b>		<b>9. AGE</b> (In years last birthday) <b>54</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>N.J.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>Harry Schmidt</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Bertha Van Rouback</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>151-12-1675</b>		<b>17. INFORMANT</b> Address <b>William Tuch, Fredricktown, Md.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease, decomp.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) <b>August 1, 1961 to August 2, 1961</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from August 1, 1961 to August 2, 1961, that (I) (we) last saw the deceased alive on August 2, 1961, and that death occurred August 2, 1961 from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>L. V. Maldve, M. D.</b>				<b>22b. DATE SIGNED</b> <b>8/2/61</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>L. V. Maldve, M. D.</b>				<b>22d. ADDRESS</b> <b>Deer's Head Hospital; Salisbury, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Aug. 5, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cecilton Cemetery</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Cecilton, Cecil Co; Md.</b>				<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Edward Yellow Millington Md.</b>			
<b>25a. REC'D BY REGISTRAR</b> <b>AUG 7 '61</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Carlton L. Kenna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9708

## CERTIFICATE OF DEATH

Reg. Dist. No. 09697

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN lb <u>Life</u>		d. STREET ADDRESS <u>213 Center St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Mae</u> Last <u>Tyndall</u>		4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-83</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Matthews Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT Mrs. Alonza Tyndall (Son) R.D. #4 (AirPort Rd) Salisbury, Maryland</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>N/A</u> 19 <u>61</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) <u>N/A</u> (County) (State)	
21. I certify that I attended the deceased from <u>7-30</u> , 19 <u>61</u> , to <u>8-9</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8-9</u> , 19 <u>61</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George H. Henning</u> M.D.		ADDRESS (Street, city or town, state) <u>Fruitland</u> DATE SIGNED <u>8-9-61</u>	
PHYSICIAN'S NAME (Type) <u>George H. Henning</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug. 13, 1961</u>	<u>Wicomico Memorial Park</u>	<u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>HOLLOWAY &amp; COMPANY</u>		<u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>AUG 14 '61</u>		<u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9708

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09698

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		d. STREET ADDRESS <b>724 S. Park Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>724 S. Park Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>WEST</b> Last <b>WEST</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>30th</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1880</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>2</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Thomas Howard</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Blades</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. J. Cecil Ragains (Daughter)</b> <b>724 S. Park Drive Salisbury, Maryland</b>		Address <b>724 S. Park Drive Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Atherosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) <b></b> (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 17:30A. 1961</b> to <b>Aug 30 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 30 1961</b> and that death occurred at <b>M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl M. Beardsley</b>		22b. DATE <b>Aug. 31 / 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl M. Beardsley</b>		22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 1, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Perry Hawkin Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Somerset Co. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>SEP 5 '61</b>	
ADDRESS <b>SALISBURY, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

2070

EXTRACT OF DEATH

2070

Y. 100. 114.

12  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY in lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				d. STREET ADDRESS <b>314 Cherry-Way</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>314 Cherry-Way</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>LLOYD DALE (Cooper) WILKINS</b>						4. DATE OF DEATH Month <b>AUGUST</b> Day <b>13th</b> Year <b>19 61</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 8, 1926</b>		9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer - Construction</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Willards, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13. FATHER'S NAME <b>Larry Cooper</b>						14. MOTHER'S MAIDEN NAME <b>Stella Hill</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>						16. SOCIAL SECURITY NO. <b>213-22-9006</b>					
17. INFORMANT <b>Mr Clarence Copper</b>						Address <b>300 E. Locust St Salisbury, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burns 100% body surface</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
916.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Fracture left tibia</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Apparent fire in bed</b>							
20c. TIME OF INJURY Month, Day, Year <b>8/13/61</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>		20f. (City or town) <b>Salisbury</b>		20g. (County) <b>Wicomico</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>Aug. 15 /1961</b>		
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county)		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 17, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Hope Cemetery</b>		22d. LOCATION (City, town, or country) <b>New Hope, Maryland</b>		22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY MARYLAND</b>						24a. REC'D BY REGISTRAR <b>AUG 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>			

